EFFECTIVE FOR SERVICES
BEGINNING _____
MONTH DAY YEAR

RETURN TO: GHP
P.O. BOX 3000
McRae, Georgia 31055

_____
MEDICAID IDENTIFICATION NUMBER

_____
VALID FOR LISTED MONTH ONLY

PRESUMPTIVE ELIGIBILITY DETERMINATION FOR PREGANCY-RELATED CARE

PATIENT'S NAME: _____
PATIENT'S ADDRESS: _____
_____
CITY: _____ STATE: _____
ZIP CODE: _____ COUNTY OF RESIDENCE: _____

TELEPHONE NUMBER: _____
SOCIAL SECURITY NUMBER: _____
PATIENT'S RECORD NO.: _____
DATE OF INTERVIEW: _____
TYPES OF INCOME:
W - WAGES/SALARIES
C - COMMISSIONS
S - SELF-EMPLOYMENT
OE - OTHER EARNINGS
P - PENSIONS
G - GIFTS/CONTRIBUTIONS
U - OTHER UNEARNED

HEALTH INSURANCE: ☐ YES ☐ NO
FORM 285 ATTACHED: ☐ YES ☐ NO
COMPANY NAME: _____
POLICY NAME: _____
POLICY NUMBER: _____

LINE NUMBER	FAMILY MEMBERS FIRST NAME MI LAST NAME SUFFIX	DATE OF MO DAY YEAR	RACE	SEX	RELATION SHIP TO PREGNANT WOMAN	MONTHLY GROSS INCOME TYPE	AMOUNT	FREQ	MONTHLY AMOUNT	MONTHLY DEDUCTIONS STANDARD WORK DEDUCTION	CHILD CARE DEDUCTION	MONTHLY NET INCOME
01					**SELF**							
02	UNBORN CHILD ☐1 ☐2 ☐3 ☐4 ☐5 ☐6											
03												
04												
05												
06												
07												
08												

SWORN STATEMENT OF MEMBER:
I UNDERSTAND THAT THIS IS A TEMPORARY DETERMINATION OF MY ELIGIBILIY FOR MEDICAID AND THAT THE DEPARTMENT OF FAMILY AND CHILDREN SERVICES WILL DETERMINE MY CONTINUING ELIGIBILITY. I ALSO UNERSTAND THAT I AM ELIGIBLE ONLY FOR CARE RELATED TO MY PREGNANCY. I CERTIFY UNDER PENALTY OF PERJURY THAT I AM A U.S. CITIZEN AND I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ABOUT MY FAMILY AND INCOME. I AGREE TO ASSIGN TO THE STATE ALL RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY SUPPORT PAYMENTS (HOSPITAL AND MEDICAL BENEFITS). I UNDERSTAND THAT MY ELIGIBILITY FOR THIS TEMPORARY ELIGIBILITY ENDS THE MONTH IN WHICH THE DEPARTMENT OF FAMILY AND CHILDREN SERVICES MAKES THE DECISION ABOUT MY CONTINUING ELIGIBILITY OR THE MONTH IN WHICH MY PREGNANCY ENDS.

TOTAL GROSS INCOME =
NUMBER IN FAMILY =
POVERTY INCOME LEVEL =

SUBTOTAL NET INCOME =
CHILD SUPPORT EXCLUSION =
TOTAL FAMILY NET INCOME =

FAMILY NET INCOME IS LESS THAN POVERTY INCOME LEVEL ☐ ELIGIBLE
FAMILY NET INCOME IS MORE THAN POVERTY INCOME LEVEL ☐ INELIGIBLE

_____ _____
DATE OF APPLICATION APPLICANT'S SIGNATURE

_____ _____ _____
DATE OF COMPLETION COMPLETED BY (PLEASE PRINT) TITLE

_____
SIGNATURE OF INDIVIDUAL COMPLETING FORM

PROVIDER CERTIFICATION:
I CERTIFY THAT THE WOMAN FOR WHOM THIS PRESUMPTIVE DETERMINATION OF ELIGIBILITY HAS BEEN MADE IS APPROXIMATELY _____ WEEKS PREGNANT WITH _____ FETUS(ES). HER EXPECTED DELIVERY DATE IS _____. I HAVE OBTAINED A SIGNED RSM APPLICATION FROM THE MEMBER AND HAVE FORWARDED IT TO THE COUNTY DEPARTMENT OF FAMILY AND CHILD-REN SERVICES.

_____ _____
PROVIDER SIGNATURE TITLE

_____ _____
PROVIDER NAME PROVIDER NUMBER

REIMBURSEMENT FOR MEDICAID SERVICES THROUGH THE PRESUMPTIVE ELIGIBILITY PERIOD DOES NOT INCLUDE INPATIENT HOSPITAL SERVICES OF DELIVERY
DMA 632 – (4-1-10)